SC93230

IN THE
MISSOURI SUPREME COURT

MARY LUSCOMBE,

Appellant,

v.

MISSOURI STATE BOARD OF NURSING,

Respondent.

Appeal from the Circuit Court of Cole County
Honorable Byron L. Kinder

RESPONDENT'S SUBSTITUTE BRIEF

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Statement of Facts

In the Spring of 2005, Mary Luscombe, RN, was working as a registered nurse in the Neonatal Intensive Care Unit ("NICU") at Columbia Regional Hospital in Columbia, Missouri. She had begun work there a year before. (Legal File from the Administrative Hearing Commission 49 ("AHC L.F."); AHC Transcript 312 ("Tr.")). During this time, Barb Brucks, RN, the manager of the NICU had held several conferences with Luscombe to address her job performance. (AHC L.F. 49-50, 542-44 and 546-48; Tr. 301, 316-24). Luscombe admitted that she was not proficient with some of the equipment. (AHC L.F. 49-50, 542-44, and 546-48; Tr. 322-23).

One of the pieces of equipment in the NICU was a cardiac monitor that provides continuous monitoring. The NICU cares for infants who are born premature, have an infection, are born with birth defects, or become sick after they are born. (Tr. 303). Because of the condition of these infants, all infants admitted to the NICU are monitored for bradycardia/apena through continuous cardiac monitoring—they all wear a cardiac monitor unless they are rooming in with their parents or are ready for discharge. (AHC L.F. 49 and 1042-44; Tr. 309).

In 2002, the hospital had developed a management protocol regarding the use of cardiac monitors in the NICU and it was in effect in 2005. It stated: "All infants admitted to the NICU are monitored for bradycardia/apnea through

continuous cardiac monitoring. . . . Suspend alarms (temporary – 3 minutes) only if infant stable or for breastfeeding/bath, etc. . . . Discontinue use of this protocol when infant is transferred out of the unit, is discharged or when rooming-in with parent(s) prior to discharge." (AHC L.F. 51 and 1042-43; Tr. 304-05).

The protocol is a series of statements that outlines the management of infants on continuous bradycardia/apnea monitors in the NICU. The protocol outlines what the monitoring is for, how the nursing staff document the apnea and the bradycardia, and it outlines what the nursing staff is to do—what the staff is to practice by. This protocol is "independent" and does not require a physician order. It is a basic care protocol. (AHC L.F. 1042-43; Tr. 305-06). Bradycardia is a drop in heart rate and apnea is the cessation of breathing. (Tr. 304-05). For an infant in the NICU, bradycardia is a heart rate that is lower than 100; a cessation of breathing for more than 20 seconds is considered apnea. (AHC L.F. 1042-43; Tr. 305). The cardiac monitor alarms will go off if the infant's heart rate drops below 90, goes over 200 or if the infant does not breath for 20 seconds. (Tr. 310). Parents are instructed to notify the nurse if they observe the cardiac monitor alarm going off. (AHC L.F. 1042)

The alarm can also be temporarily suspended for three minutes if the nurse remains at the bedside watching the baby. (Tr. 311). When the alarm is suspended, it prevents it from making an audible noise for three minutes. The

nurse can still see what is going on by looking at the monitor. If the alarm is temporarily suspended, the nurse is to remain at the bedside directly observing the infant and should stay there until the alarm is turned back on or three minutes has elapsed and it has come back on automatically. The nurse should not step away from the bedside or turn her back on the infant but must be standing there watching and making sure that the infant is going to recover the heart rate or the oxygen level or whatever set off the alarm. (AHC L.F. 51; Tr. 310-11 and 346).

In mid-May, Brucks had sent an e-mail regarding the cardiac monitors, stating that the monitors were not to be suspended. Luscombe admitted she received a copy of the e-mail, and that although she had been confused about the protocol, she did not ask anyone for clarification. (AHC L.F. 52-53, 548; Tr. 294-95, 311-12 and 427).

On May 29, 2005, Luscombe was working in the NICU with another Neonatal ICU staff nurse, Christine Koestner, who worked part-time. They shared a pod where there were six infants in cribs, and they were each assigned to three. (AHC L.F. 51, 1044, and 1062; Tr. 314 and 340).

Nurses in the NICU sometimes care for another nurse's babies during lunch breaks or when a nurse is occupied with another baby. (AHC L.F. 51). The alarm on the cardiac monitor of one of the infants assigned to Koestner went off several times. On more than one occasion, Luscombe suspended the

alarm on the cardiac monitor, turned the monitor so she could see it, and walked away so that she was not next to the infant's bedside. (AHC L.F. 51, 545, 546, 548, and 1063-66; Tr. 316, 322, 411, 427-28, and 430). During one of the times that Luscombe suspended the alarm, the infant's heart rate became low, and the infant's parents had to call for Luscombe to come and care for their child. The parents complained to Brucks about the suspension of the alarm. (AHC L.F. 51, 545, 546, and 548; Tr. 315-16).

Brucks and Luscombe met about the suspension of the alarms. Luscombe admitted that she had suspended the alarms and that she would do it again if she "had to." She stated that she was busy and that she had turned the monitor so that she could see it. (AHC L.F. 53, 546, and 1063-66; Tr. 322-23).

Brucks met with Luscombe again and reviewed an action plan that Luscombe had submitted. Brucks did not believe that Luscombe's plan addressed critical clinical issues and Brucks believed that Luscombe had not grasped the seriousness of her actions. Brucks felt that it was too risky to put Luscombe back to work as an RN. Luscombe was terminated on June 20, 2005, *"for lack of critical thinking, subsequent action of suspending the alarms, and failure to recognize the critical nature of her decisions."* (AHC L.F. 49, 53, 545, 546, and 548; Tr. 323) (emphasis added).

In a letter to one of the Board's investigators, written in October 2005, Luscombe admitted that she suspended the alarm, left the infant's bedside, and

positioned the monitor so she could see it away from the bedside. (AHC L.F. 53-54 and 1061-69; Tr. 427-28 and 430; Respondent's Substitute Appendix A4-A12 ("Resp. Sub. App.")). When interviewed by another of the Board's investigators on November 7, 2005, Luscombe admitted that she had suspended the cardiac monitor alarm of an infant in the NICU. (AHC L.F. 54; Tr. 293-94).

After Luscombe was terminated from the hospital, she found employment on August 2, 2005, as a RN with Integrity Home Care in Columbia, Missouri. She provided nursing services in the In-Home Services, Private Duty Nursing, and Private Pay Departments. She was compensated for patient visits. Integrity provides services to Medicaid clients and is responsible for having adequate documentation of nurse visits. Integrity bills MO HealthNet and pays its nurses for these visits. (AHC L.F. 54, 552-63; Tr.155-64 and 186).

As a visiting nurse for Integrity, Luscombe was responsible for having her patients sign the nurse care visit reports to show that the services had been performed. (AHC L.F. 54-55 and 720; Tr. 155; Resp. Sub. App. A18). The AHC found that Luscombe signed the names of four clients—J. B., T.W., L.F., and K.S.—on the client signature lines on some of the nurse visit reports and that she represented they were the clients' signatures. (AHC L.F. 55). Although Luscombe testified that she did not forge patients' signatures and did not falsify any documents for Integrity, the AHC found that her testimony was not credible in this regard. The AHC based its decision in part on the fact that the AHC did

not find Luscombe's testimony credible in regard to her failure to turn in records. (AHC L.F. 66-67).

Integrity's In-Home Services Nursing Manual states: "All nurse visit forms will be turned in every week, as they are part of your time slips." Integrity's weeks ran from Saturday to Friday. Paperwork from the prior week was due on the next Monday at noon. (AHC L.F. 55 and 714; Tr. 107-08 and 440; Resp. Sub. App. A14). Luscombe was trained in Integrity's polices and the CSRs. She signed a statement that she had read and understood the job description of an RN and that she could perform the essential functions. (AHC L.F. 55 and 1045, 1053-54; Resp. Sub. App. A20 and A28-29).

Luscombe failed to turn in nurse documentation for visits that she said she had made to clients and for missed visits while she was employed at Integrity. She resigned from her employment at Integrity on October 17, 2007, without turning in documentation required by Integrity. Integrity did not realize the extent of the documentation issues until after Luscombe left her employment there. (AHC L.F. 55, 564-666, 727-900, 982-90, and 1015-30; Tr. 120 and 139).

In March 2008, Randa Kullman, RN, BSN, became the in-home nurse supervisor at Integrity. One of her tasks was to obtain missing nurse documentation from Luscombe, who was no longer employed there. (AHC L.F. 55, 478-85, 690-712; Tr. 97, 110, 112-13, and 118). Kullman knew the

importance of record keeping as she had been disciplined by the Board for record-keeping issues years earlier, was placed on probation, served her probation and has not had any issues since that time. (Tr. 98-99).

Kullman started to request records from Luscombe in May 2008. Kullman instructed Luscombe that if she did not have the signatures, she would not be able to take documents that required client signatures to the clients' homes to have them signed because she was no longer employed by Integrity. Another Integrity employee also made several phone calls to Luscombe to ask for the records. (AHC L.F. 56, 478-85, 690-712; Tr. 118 and 169).

It was not until June 6, 2008, when Luscombe turned in the documentation for approximately 53 nurse visits that took place from January through August 2007. (AHC L.F. 56, 564-666; Tr. 120). Luscombe turned in a second set of nursing notes in August of 2008, representing approximately 174 nurse visits with approximately 19 clients from January through August 2007. (AHC L.F. 56, 727-900, and 982-90; Tr. 139).

Integrity also had a "show-up" policy that provided that the employee should contact the patient the night before. If there is a missed visit, the nurse must fill out a missed visit form. (AHC L.F. 56 and 715). Integrity tracks when nurses visit clients with a "Telephony" system. Once in the client's home, the nurse calls an 800 number from the client's phone that clocks the nurse into the visit. When the nurse is finished with the visit, the nurse calls the 800 number

again to clock out. The clients' phones are connected to this system, so the nurse must make the call from the clients' homes in order for the time to be clocked in. Integrity sends its bills and is paid based on the information in the Telephony system. (AHC L.F. 56, 690-712, 991-99, and 1056-60; Tr. 80-87, 115-16; Resp. Sub. App. A31-A44).

Luscombe clocked in visits through the Telephony system in a number of clients' homes for whom she failed to turn in the required documentation to Integrity on a timely basis. For nine of these visits, Luscombe clocked in that she was performing an authorized nurse visit when other documentation subsequently showed that the patient was not at his or her home. Luscombe was compensated for these visits. (AHC L.F. 56-57, 470-85, 564-712, 1015-39; Tr. 110-18).

When Luscombe ultimately turned in the records, there were discrepancies. There were visits that had been logged into the Telephony system (and thus paid by Medicaid to Integrity and by Integrity to Luscombe) as authorized nurse visits. Yet, the written records reflect that the client had not been present at the home ("a missed visit"). Because Medicaid does not pay for missed visits, Integrity refunded Medicaid for the amount of the visits. Integrity did not pay its nurses for missed visits without proper documentation that the nurse called the day before to confirm the visit. (AHC L.F. 57, 690-712, 982-99, 1058; Tr. 155-64 and 186; Resp. Sub. App. A15 and A36-A44).

Before she began work at Integrity on August 2, 2005, Luscombe had difficulty in her personal life that she made issues in this case. Luscombe used her marital issues as a defense to the Board's allegations concerning the Integrity records. But, Luscombe had separated from her husband and moved off the family farm on June 10, 2005—*before* going to work at Integrity. The parties filed for divorce and on October 26, 2005, Mr. Luscombe filed an ex parte order against Luscombe for adult abuse/stalking. It was granted. The divorce was eventually granted and on June 9, 2007, Luscombe was allowed to go to the family farm to pick up nonmarital property. (AHC L.F. 54 and 70; Tr. 448-49).

The AHC found that the clear timeline of events made Luscombe's credibility questionable. It found that the records in question (for January 2007 through August 2007) would have been created *after* she left the family home and *after* her husband had filed an ex parte order against her (June 10, 2005 and October 26, 2005, respectively). As the AHC noted: "In order for Luscombe's contention to be true, she would have had to store records at a place where she was no longer living and to which she no longer had access." Thus, the AHC found that Luscombe's excuse for the untimely records was not credible. (AHC L.F. 70).

At the disciplinary hearing before the Board, Luscombe offered a different excuse as to why she did not timely turn in the records. She stated that the records were locked in the trunk of her car that was on her husband's property.

(Board of Nursing Transcript "BON Tr." 72-74). Board member Adrienne Fly questioned Luscombe about the timing of these records being locked in the trunk of her car on her husband's property and she stated: "You left [the residence] prior to working for Integrity so those documents could not have been in the car if you left the car there before you moved out." (BON Tr. 73).

The Board filed an amended complaint with the Administrative Hearing Commission seeking the Commission's determination that Luscombe's license was subject to discipline. (AHC L.F. 3-33). Luscombe filed an answer on March 6, 2009. (AHC L.F. 34-47). Hearings were held before Commissioner John J. Kopp. (AHC L.F. 48-49; Tr. 1, 203, and 349). Commissioner Karen A. Winn read the full record, including all the evidence, and issued Findings of Fact, Conclusions of Law, Decision, and Order on November 24, 2010. (AHC L.F. 48-72). The Board held a disciplinary hearing on March 4, 2011. Luscombe appeared in person and was represented by counsel. On March 9, 2011, the Board issued its order revoking Luscombe's license. (AHC L.F. 81-82).

Luscombe then filed an action in circuit court. She also requested a stay of the administrative decisions, which was granted. (Circuit Court ("Cir. Ct.") L.F. 111). Briefs were filed and arguments were held and the Court entered a judgment affirming the decisions of the AHC and the Board. (Cir. Ct. L.F. 16-22). Luscombe filed a notice of appeal (Cir. Ct. L.F. 10-13). She again

requested a stay of the administrative decisions and it was granted by the court of appeals on April 18, 2012.

The court of appeals issued a decision on January 8, 2013, and affirmed in part and reversed in part the AHC decision and remanded the case to the Board for a new disciplinary hearing. This Court ordered the case transferred.

Argument

Standard of Review

In this case, the Court's role is to review the administrative record to determine whether the agency's action is supported by competent and substantial evidence. *Moheet v. State Bd. of Registration for the Healing Arts*, 154 S.W.3d 393, 397 (Mo. App. W.D. 2004). This Court clarified this standard in *Albanna v. State Bd. of Registration for Healing Arts*, 293 S.W.3d 423, 428 (Mo. 2009) (Resp. Sub. App. A60-71), in which the Court stated:

> The correct standard of review for administrative decisions governed by article V, section 18 of the Missouri Constitution . . . is "whether, considering the whole record, there is sufficient competent and substantial evidence to support the [agency's decision]. This standard would not be met in the rare case when the [agency's decision] is contrary to the overwhelming weight of the evidence." (citation omitted)

The Court's authority to review an agency's decision is also governed by § 536.140, RSMo, which states in pertinent part that "the court shall not substitute its discretion for discretion legally vested in the agency, unless the court determines that the agency decision was arbitrary or capricious." Section 536.140.5, RSMo. The reviewing court may not substitute its judgment for that of the agency even if the evidence might support findings of fact different from

those found by the agency. *Percy Kent Bag Co. v. Mo. Comm'n on Human Rights*, 632 S.W.2d 480, 487 (Mo. 1982); *Prokopf v. Whaley*, 592 S.W.2d 819, 823 (Mo. 1980). And, "[t]he AHC is the sole judge of witness credibility and the weight and value to be given to the evidence, and we are not permitted to substitute our judgment for the judgment of the AHC." *Kerwin v. Mo. Dental Bd.,* 375 S.W.3d 219, 230 (Mo App. W.D. 2012) (Resp. Sub. App. A90-101).

Furthermore, the reviewing court "will not reverse the decision of an administrative agency that reaches the right result even if it gave a wrong or insufficient reason for its ruling." This Court should affirm if it "could reach the same result based on the same evidence and without weighing evidence or assessing witness credibility (internal citations omitted)." *Dale v. Rahn*, 330 S.W.3d 107, 111 (Mo. App. S.D. 2010). While the Board had the burden of proof at the administrative hearing, on review, Luscombe has the burden to prove that the decision of the agency was erroneous. *Johnson v. Mo. Dep't of Health and Senior Servs.*, 174 S.W.3d 568, 579 (Mo. App. W.D. 2005).

I. The Administrative Hearing Commission did not err in finding cause to discipline Mary Luscombe's nursing license for her conduct while employed by Columbia Regional Hospital (Responding to Appellant's Point I).

A. The AHC properly found that expert testimony was not necessary to prove that Luscombe's conduct in suspension of the NICU cardiac alarm constitutes gross negligence.

a. Section 490.065, RSMo 2000, permits but does not require expert testimony.

An expert is not required to assist the AHC in determining whether a nurse's violation of hospital protocol constitutes gross negligence. Section 490.065.1, RSMo 2000 (Resp. Sub. App. A1), governs the use of expert testimony and provides in pertinent part:

> In any civil action, if scientific, technical or other specialized knowledge will assist the trier of fact to understand the evidence or to determine a fact in issue, a witness qualified as an expert by knowledge, skill, experience, training, or education ***may*** testify thereto in the form of an opinion or otherwise. (emphasis supplied).

Luscombe's argument that an expert is required essentially converts the word "***may***" in the above statute to the word "***shall***" in *all* cases involving the medical treatment administered by *any* kind of medical professional.

This Court in *State Bd. of Registration for the Healing Arts v. McDonagh*, 123 S.W.3d 146, 154 (Mo. 2003) held that § 490.065, RSMo, is the standard for admissibility of expert testimony in contested administrative proceedings. As if

this was not enough, Judge Wolff, in an opinion concurring in part and dissenting in part stated: "Read the statute. Section 490.065 is written, conveniently, in English. It has 204 words. Those straightforward statutory words are all you really need to know about the admissibility of expert testimony in civil proceedings. Section 490.065 allows expert opinion testimony where 'scientific, technical or other specialized knowledge will assist the trier of fact . . . .'" *Id*. at 160. In addition, the use of an expert is discretionary, as § 490.065.1, RSMo 2000, uses the term "may."

In *Albanna*, 293 S.W.3d at 430, this Court specifically held that the AHC may make a conclusion of unprofessional conduct in light of the evidence presented in that case without an expert specifically testifying that the doctor's conduct was unprofessional. Indeed, the use of an expert is the exception and not the general rule. In *Housman v. Fiddyment*, 421 S.W.2d 284, 289 (Mo. 1967), this Court noted:

> 'The necessity for such [expert] testimony arises where the subject matter of an inquiry is so far removed from the realm of common experience that the ordinary jury, even when the facts are fully placed before them, cannot fairly be expected to draw a correct inference therefrom, and at the same time no person competent to draw such an inference has personal knowledge of the facts.' (citations omitted).

This Court also held in *Stone v. Mo. Dep't of Health and Senior Servs.*, 350 S.W.3d 14, 21 (Mo. 2011) (Resp. Sub. App. A72-A83), that by the plain language of § 490.065.1, RSMo 2000, expert testimony is permissive and "[i]t is within the adjudicator's discretion to determine 'necessity' of expert testimony (citation omitted). The plain language of the statute leaves the determination up to the trier of fact–and the AHC specifically held that it did not need an expert. (AHC L.F. 63).

b. A protocol or a doctor's order establishes a professional duty for a nurse without the need of an expert.

Section 335.066.2, RSMo, provides cause to discipline a nursing license for, among other things: "(4) Obtaining or attempting to obtain any fee, charge, … or other compensation by fraud, deception or misrepresentation; (5) Incompetency, misconduct, gross negligence … in the performance of the functions of duties of any profession licensed or regulated by sections 335.011 to 335.096;" and (12) "Violation of any professional trust or confidence[.]"

The AHC found, without the aid of an expert, that it was gross negligence when Luscombe suspended the cardiac alarm in the NICU of the hospital. The trier of facts, an experienced Commissioner, stated: "no expert testimony was needed because it was capable of concluding that failure to obey hospital directives or protocol may constitute 'indifference to professional duties' without expert testimony." (AHC L.F. 63). That finding of "indifference" made this an

act of "gross negligence," which is "an act or course of conduct which demonstrates a conscious indifference to a professional duty." The mental state for gross negligence is equivalent to recklessness. *Duncan v. Mo. Bd. for Architects, Prof'l Eng'rs and Land Surveyors*, 744 S.W.2d 524, 533, n.6 (744 S.W.2d 524 (Mo. App. E.D. 1988). The AHC found that Luscombe's conduct constituted gross negligence and a violation of a professional trust in violation of the Nursing Practice Act, § 335.066.2(5) and (12), RSMo Cum. Supp. 2009, because her "professional duty" was to obey the hospital's written directive, a protocol regarding the alarms in the NICU, and she did not. (AHC L.F. 63).

This case is directly comparable to the line of cases that have held that expert testimony is not required when the basis of a claim of negligence is a nurse's failure to follow a doctor's orders. *Daugherty v. N. Kansas City Mem'l Hosp.*, 570 S.W.2d 795, 797 (Mo. App. K.C.D. 1978) (Resp. Sub. App. A84-A86), stated:

> '[T]he nurse had but to read all the physician's instructions appearing on the Order Sheet in order to avoid the mistake she made. It appears in the record by expert testimony that the very purpose of the Order Sheet is to guide the nurses in carrying out the doctor's orders. This being so, we think the calling of an expert witness to testify that the failure of a nurse to follow the doctor's written instructions was a violation of the expected standards of her

> profession, would be an empty gesture. . .we think the particular issue did not require the establishment of standards by experts.' (citation omitted).

See also, Rush v. Senior Citizens Nursing Home Dist. of Ray County, 212 S.W.3d 155, 161 (Mo. App. W.D. 2006) and *Redel v. Capital Region Med. Ctr.*, 165 S.W.3d 168, 174 (Mo. App. E.D. 2005). Doctor's orders are directly comparable to a hospital's basic care protocol.

c. The hospital protocol regarding cardiac monitors did not give Luscombe discretion.

The hospital had a written directive in place that addressed the suspension of cardiac alarms in the NICU: "All infants admitted to the NICU are monitored for bradycardia/apnea through continuous cardiac monitoring . . . Suspend alarms (temporary – 3 minutes) only if infant stable or for breastfeeding/bath, etc. . . ." (AHC L.F. 51 and 1042-43; Tr. 305-11).

Luscombe admitted three times that she failed to follow the hospital protocol and repeatedly suspended the alarms on the cardiac monitors of an infant in the NICU and walked away from the infant's bedside. She also stated that she would do it again if she "had to." (AHC L.F. 53-54 and 1061-69; Tr. 293-94, 322-23, 427-28 and 430; Resp. Sub. App. A4-A12).

Luscombe's supervisor, Nurse Brucks testified about cardiac monitoring protocol. It is a series of statements that outlines the management of infants on

continuous bradycardia/apnea monitors in the NICU. It is a basic care protocol that was developed to direct nurses in carrying out the medical care to be given in the NICU. (AHC L.F. 1042-43; Tr. 305-06). Parents are even instructed to notify the nurse if they observe the cardiac monitor alarm going off. (AHC L.F. 1042) Brucks also testified as to Luscombe's deviation from the hospital protocol in suspending the alarms. (Tr. 311-12, 316, and 322).

A nurse should not unilaterally disregard a physician's instruction or hospital protocol. If Luscombe wanted an exception to the protocol, and to suspend the alarms as she did, it would necessitated a physician's order.

Suspending the alarms was a violation of the protocol and, therefore a deviation from Luscombe's professional duty to follow protocol. Her actions are directly comparable to those in *Stone,* 350 S.W.3d at 20-25, where a nurse failed to follow the written directive that was an individualized care plan for a patient. This Court determined that for a nurse, the individualized care plan established the standard of care for that patient when she refused to take her medications. "The department put forth ample evidence of the applicable 'standard of care' through the testimony of [witnesses] about [the client's] individualized care plan." *Id.* at 24. Stone's actions violated the standard of care because they were contrary to the care plan, and expert testimony was not required. *Id.* at 23. Nowhere in *Stone* did this Court leave room for Stone to argue that in addition to the written directive, the Department of Health and Senior Services was

required to bring to the hearing an expert to testify that the written directive established the standard of care. *Id.* at 14-29.

Luscombe's actions violated the hospital's protocol regarding suspension of the cardiac monitors, which established the standard of care for infants in the NICU. Luscombe's chosen conduct constituted a gross deviation from the standard of care that a reasonable person would exercise in the situation. No expert was required. Here, as in *Stone*, *supra,* the written directives in the protocol in set the standard of care. If that is no longer enough, then this court should reverse *Stone*.

d. Though case law requires expert testimony when a physician is charged with erroneously using his discretion, it does not require expert testimony when a nurse violates a hospital protocol that does not give her discretion.

Luscombe relies on *Tendai v. Mo. State Bd. of Registration for the Healing Arts*, 161 S.W.3d 358 (Mo. 2005) (overruled on other grounds) and *Dine v. Williams,* 830 S.W.2d 453 (Mo. App. W.D. 1992) for the proposition that expert testimony is necessary for finding gross negligence. But, *Tendai* and *Dine* are distinguishable in a very important way from the case at bar. These two cases involve whether *physicians* have violated the standard of care, but this case involves a *nurse*. Nursing, while in the medical field, is a different practice than

physicians. For medical services, the standard of care guides the physician in terms of what is the proper diagnosis, proper procedure, proper medication, and proper action to take in a given circumstance. Once the decision has been made, the application of care is delegated to a nurse. It can be done by direct instruction or by way of protocol as shown in I.A.*b., supra*.

Luscombe also compares this case to the more complex medical malpractice trials involving physicians, decided by juries, such as *Dine, supra,* and *Hart v. Steele*, 416 S.W. 2d 927 (Mo. 1967). This case does not involve physicians or dentists and it is not a jury case. The AHC was the trier of fact—an experienced administrative law judge. The AHC found that the issues in this case are not comparable to more complex cases such as *McDonagh*, *supra,* and *Albanna*, *supra,* which involved the standards for vascular disease treatment and neurosurgery. The AHC held that while it might require expert testimony to find incompetence for the conduct at hand, it was able to find that Luscombe's conduct constituted gross negligence without expert testimony. (AHC L.F. 63).

Luscombe's reliance on *Oakes v. Mo. Dep't of Mental Health*, 254 S.W.3d 153 (Mo. App. E.D. 2008), is also misplaced. That case did not involve a licensed professional, it involved a mental health worker, and there was conflicting testimony in the record. In this case, contrary to Luscombe's allegation that there is no evidence of the standard of care, there was written protocol as well as the testimony of two experienced nurses who agreed on the protocol. The AHC

Commissioner did not use her own standard of care, as alleged by Luscombe. The Commissioner applied the facts in the record to the law and issued a reasonable decision.

e. Even if the protocol did not sufficiently establish the standard of care, it is within the AHC's expertise to determine that the alarms for infants in the NICU should not be suspended and a nurse walk away from the infant's bedside.

Even if the protocol did not sufficiently establish the standard of care, it is within an experienced Commissioner's expertise to determine that the alarms for these infants should not be suspended and a nurse walk away from the infant's beside. It must be kept in mind that the infants in the NICU are born premature, have an infection, are born with birth defects, or become sick after they are born. Continuous cardiac monitoring is required. In fact, it is comparable to a case where a sponge is left in a patient. *See Crump v. Piper,* 425 S.W.2d 924, 926 (Mo. 1968). Both are so egregious, that an expert is not required to prove a violation of a professional duty. Here the experienced Commissioner could determine, without an expert, that in suspending the alarms and then walking away, Luscombe showed a conscious indifference to a professional duty, which constituted gross negligence.

But, as noted earlier, the alarm requirement was a written directive like the one in *Stone*, *supra,* or the doctors' orders in *Daugherty*, *supra, Rush*, *supra,* and *Redel, supra*; and therefore it was unnecessary for the Commissioner to rely on her own judgment. An expert is not required when a nurse fails to follow a doctor's order, *Daugherty,* 570 S.W.2d at 797, *Rush,* 212 S.W.3d at 161, and *Redel*, 165 S.W.3d at 174, a patient's care plan, *Stone*, 350 S.W.2d at 23, or a hospital protocol.

B. The AHC correctly interpreted the hospital's protocol.

At the hearing, the Board produced two witnesses from the NICU, Brucks and Koestner, who explained the set up of the NICU as well as the hospital protocol. Although Brucks and Koestner were lay witnesses, they are professionals in their field. They explained the need for neonatal monitoring and the protocol. (AHC L.F. 1040-41; Tr. 304-12, 338-39, 342-43). The protocol provides that cardiac alarms can be suspended for three minutes, *but only in very limited circumstances: if the infant is stable or breastfeeding*. (AHC L.F. 1040-41). The instances when Luscombe suspended the alarms do not fall under these circumstances: *she admitted that she suspended the alarms, turned the monitor, and walked away from the bedside*. On one occasion, the infant's parents had to call for Luscombe to come and care for their child after Luscombe had suspended the alarm and the infant's heart rate became low. The infant was not stable and the mother was not breastfeeding. This protocol was

reiterated about a week before this incident in an email from Brucks. The email stated that the monitors were not to be suspended. Luscombe also admitted that she received the email, but did not ask Brucks any questions about it. (AHC L.F. 51-53, 545, 546, 548, 1061-69; Tr. 294-95, 311-12, 315-16, and 427; Resp. Sub. App. A4-A12). Although the actual email was not produced, witnesses testified to its existence.

Luscombe argues that the protocol was incorrectly expanded by the AHC when it found that the alarm could be suspended for three minutes if the nurse is at the bedside watching the baby. (Appellant's Brief 18-19) ("Appellant's Br."). However, both Brucks and Koestner confirmed that protocol told the nurse what to do in response to the alarm sounding. As Koestner explained: "You can suspend them as long as you're standing there watching and making sure the baby is going to recover the heart rate or the oxygen level or whatever triggered the alarm." (Tr. 346. See also, Tr. 310-11). If the alarm is suspended, the nurse should not step away from the bedside or turn her back on the infant. (AHC L.F. 51; Tr. 310-11 and 346).

In other words, when the nurse hears the alarm and goes to the infant's bedside, he or she does not need to listen to the alarm going off the whole time he or she is at the bedside trying to address what is wrong with the infant. That is why it is important for the nurse to remain at the bedside and not walk away as Luscombe did. The AHC correctly summarized it in paragraph 13:

> The alarm can also be temporarily suspended for three minutes if the nurse is at the bedside watching the baby. When the alarm is suspended, it prevents all the alarms from making an audible noise for three minutes. The nurse can still see what is going on by looking at the monitor. When the alarm is suspended, the nurse should not step away from the bedside or turn her back on the infant.

(AHC L.F. 51).

In essence, the issue of whether the protocol was improperly expanded by the AHC, is not material. Either the hospital had the written protocol or it had the written protocol with the explanation of what to do when a nurse is at the bedside when an alarm is sounding. Regardless, Luscombe violated both. The AHC properly determined that it was capable of concluding that Luscombe's "failure to obey hospital directives or protocol may constitute 'indifference to professional duties' without expert testimony." (AHC L.F. 63).

C. The AHC's finding of cause to discipline Luscombe's license for her actions in the hospital's NICU is supported by competent and substantial evidence in whole the record.

Looking at the whole record, the evidence produced showed that the hospital had a protocol as to when the alarms on the cardiac monitors could be suspended in the NICU unit. This protocol was explained in the written

protocol, the email confirming it, and the testimony of the nurses. By her own admission, Luscombe stated three times that she suspended the alarms. The evidence produced is probative as to whether Luscombe violated the nursing practices act and constitutes competent and substantial evidence to support the AHC decision.

Schnell v. Zobrist, 323 S.W.3d 403, 412 (Mo. App. W.D. 2010), explains competent and substantial evidence. *Schnell* states:

> The competent and substantial evidence standard is not a standard of proof but, rather, is a standard of judicial review of an administrative agency's decision pursuant to section 536.140.2, RSMo Cum. Supp. 2009. Substantial evidence, which necessarily implies competent evidence, means:
>
> '[E]vidence which, if true, has probative force upon the issues, i.e., evidence favoring facts which are such that reasonable men may differ as to whether it establishes them; it is evidence from which the trier or triers of the fact reasonably could find the issues in harmony therewith; it is evidence of a character sufficiently substantial to warrant the trier of facts in finding from it the facts, to establish which the evidence was introduced.'

> Both parties to a contested matter can present substantial evidence. Indeed, when a court reviews the record to determine if an agency's decision is supported by competent and substantial evidence, it may also find that there is competent and substantial evidence in the record to support a contrary decision. ***In such circumstances, the court is to affirm the agency's decision.***

(emphasis supplied) (footnote and citations omitted)

D. The AHC's finding of cause to discipline Luscombe's license for her actions in the hospital's NICU is not arbitrary, capricious, or unreasonable.

The AHC outlined five pages of findings of fact regarding the incident in the NICU. (AHC L.F. 49-54). The finding of cause to discipline relies on detailed findings regarding the circumstances of the NICU and the protocol there. (AHC L.F. 58-63). There is objective data and there is no surmise or guesswork in its decision.

In *Bd. of Educ. of the City of St. Louis v. Mo. State Bd. of Educ.*, 271 S.W.3d 1, 11 (Mo. 2008), this Court held:

> An administrative agency acts unreasonably and arbitrarily if its decision is not based on substantial evidence. Whether an action is arbitrary focuses on whether an agency had a

> rational basis for its decision. Capriciousness concerns whether the agency's action was whimsical, impulsive, or unpredictable. To meet basic standards of due process and to avoid being arbitrary, unreasonable, or capricious, an agency's decision must be made using some kind of objective data rather than mere surmise, guesswork, or 'gut feeling.' An agency must not act in a totally subjective manner without any guidelines or criteria.

Id. It is obvious in the twenty-five page decision of the AHC that there is nothing whimsical or impulsive in its decision. (AHC L.F. 48-72).

E. There is sufficient evidence in the record to support the AHC's finding of cause to discipline Luscombe's license for violation of a professional trust or confidence.

Luscombe's actions in suspending the cardiac alarms in the NICU several times violate the professional trust and confidence. Some of the most vulnerable patients—the infants in the neonatal intensive care unit—relied on her special skill and knowledge to care for them properly. She violated that with the infant in May 2005 when she suspended the alarms on multiple occasions and walked away from the infant's bedside. Her employer, the hospital, also had a relationship of professional trust and confidence that was violated when she suspended the cardiac alarms. The hospital relied on Luscombe to follow its

protocol. Luscombe did not follow the protocol. The professional trust and confidence that Luscombe had with the hospital was violated.

A professional trust or confidence is engendered by a party's reliance on the special knowledge and skills evidenced by professional licensure. *Trieseler v. Helmbacher,* 168 S.W.2d 1030, 1036 (Mo. 1943). A "[p]rofessional trust . . . may exist not only between the professional and his clients, but also between the professional and his employer and colleagues." *Cooper v. Mo. State Bd. of Pharmacy*, 774 S.W.2d 501, 504 (Mo. App. E.D. 1989) (Resp. Sub. App. A87-A89).

Luscombe argues that the AHC's finding of a violation of professional trust and confidence is based on an incorrect finding of fact regarding the cardiac monitor protocol. There was no incorrect finding of fact; the AHC properly found that Luscombe violated hospital protocol, and therefore Luscombe did violate the professional trust and confidence of both her employer and the patient. No expert was needed as pointed out in Section I.A., *supra*.

II. The AHC did not err in finding cause to discipline Luscombe's nursing license for her conduct regarding records of Integrity Home Health Care clients (Responding to Appellant's Point II).

A. The Commissioner's refusal to admit affidavits regarding signatures was proper under § 536.070(12), RSMo 2000.

Paperwork for some of the nurse visits was turned in late and the Board alleged that some of them contained forged signatures. (AHC L.F. 26-28). At the hearing on November 12, 2009, Luscombe offered four affidavits, of J.S., L.F., E.J., and M.N., that were purportedly signed by Integrity patients for whom Luscombe had provided nurse visits. (Tr. 262; L.F. 516-36). The Board's objection to the introduction of the affidavits, based on § 536.070(12), RSMo 2000 (Resp. Sub. App. A3), was sustained. That provision states that in any contested case:

> Any party or the agency desiring to introduce an affidavit in evidence at a hearing in a contested case may serve on all other parties (including, in a proper case, the agency) copies of such affidavit in the manner hereinafter provided. . . however, that if such affidavit shall have been served less than eight days before the hearing such objection may be served at any time before the hearing or may be made orally at the hearing. If such objection is so served, the affidavit or the part thereof to which objection was made, may not be used except in ways that would have been permissible in the absence of this subdivision.

Luscombe's previous attorney made an offer of proof regarding the affidavits. (Tr. 263-68 and 287-88). In her brief, Luscombe argues that the

affidavits should have been admitted, yet she fails to reference the above statute. (Appellant's Br. 32-34). Luscombe's previous attorney had not served the affidavits upon the Board's counsel eight days before the hearing. So, when they were offered at the hearing, the objection was sustained. (Tr. 262). Because they were not served in accordance with § 536.070(12), RSMo 2000, the Commissioner properly excluded them. *See Homa v. Carthage R-IX School Dist.*, 345 S.W.3d 266, 282, n. 14. (Mo. App. S.D. 2011).

Two of the affiants, E.J. and M.N., testified later at the hearing on January 19, 2010. (Tr. 372-78). Regarding the other two affidavits that were not admitted, only one affiant, L.F., was part of the Board's amended complaint. J.S., who supplied another affidavit, was not one of the clients whose signatures were alleged to be forged. (AHC L.F. 26-27; Tr. 265). Therefore, even if the two affidavits had been accepted into evidence, there were still three more patients for whom the AHC found that Luscombe had turned in paperwork with forged signatures. (AHC L.F. 55)

B. Expert testimony is not necessary to prove that falsifying records and turning in records into an employer months after a nurse visit or a missed visit violates the standard of care under § 335.066.2(4), (5), and (12).

In two sentences citing no authority, Luscombe says that the records claims also require expert testimony. (Appellant's Br. 37). The issues involving

Luscombe's conduct regarding the records at Integrity also do not require any specialized knowledge or expertise of an expert. Integrity's policy required that patient records be turned in on a weekly basis. (AHC L.F. 714; Tr. 107-08 and 440; Resp. Sub. App. A14). Luscombe had been trained in Integrity's policies on record-keeping and understood that it was an essential function of her job as a registered nurse. (AHC L.F. 1045-55; Tr. 440; Resp. Sub. App. A20-30). If patient records are to be turned in on a timely basis, it does not take an expert to assist the AHC to determine that those records should not be turned in months and up to a year later.

As previously mentioned, *McDonagh, supra,* involved the medical issues of a special treatment for vascular disease. The issues involving Integrity are not of a complex medical nature. Any common person, and especially an experienced administrative law judge, can determine that turning in approximately 245 patient records for approximately 19 patients up to a year late evidences cause to discipline Luscombe's nursing license. An expert is not required.

The AHC could also understand the testimony of the Board's witnesses from Integrity who testified about the Telephony system. They explained the sequence of events: Luscombe clocked in through the Telephony system when she should not have, Luscombe did not turn in "missed visit" records those weeks, Integrity paid Luscombe, and Integrity billed Medicaid for the visits.

O*ver a year later,* Luscombe turned in "missed visit" records, and then Integrity in turn reversed the Medicaid billing for the visits that were not authorized nurse visits. (AHC L.F. 56-57, 470-85, 564-712, 991-99, 1015-39, and 1056-60; Tr. 80-87, 110-18; Resp. Sub. App. A31-A44). An expert is not required to understand that Luscombe's conduct put Integrity at risk for Medicaid fraud.

Similarly, it does not take an expert for the AHC to understand that nurses should not forge patient signatures, as was proven by the expert testimony of Don Lock. He opined that he was virtually certain that the patients in question did not sign the patient records that were turned in months after they were due. Lock also testified that he found similarities between the questioned signatures and the known signatures of Luscombe for several of the patients. Because they were copies, Lock could not opine with absolute certainty, but he did testify that he could opine with a highly probable or virtually certain opinion. (AHC L.F. 1013-14; Tr. 222-45 and 281; Resp. Sub. App. A45-A46).

Once the Commission received Lock's testimony, it would not need another expert to testify that a nurse should not forge patient signatures on patient records, in order for it to understand that this conduct would violate the standard of care and subject her nursing license to discipline. Even if an expert had been presented by the Board, what specialized knowledge would have been utilized to assist the AHC in determining that patient signatures should not be

forged, and patient records should not be falsified and turned in months, even up to a year, after they were due?

In summary, the AHC was perfectly capable of reaching intelligent conclusions on the issues presented in this case without the necessity of an expert witness to assist. The ultimate issue for decision, whether Luscombe's conduct is subject to discipline, is a "matter which, under the facts and circumstances in evidence, . . . [is] within the ken and competence of" the Commission to decide. *See Housman* at 292.

C. The AHC's finding of cause to discipline Luscombe's license for her actions while working for Integrity is supported by competent and substantial evidence in whole the record.

The Board proved that Luscombe did not turn in documentation for the service of Integrity's clients for the months of January through August 2007 until June and August 2008—in some cases over a year later—for a total of approximately 245 records for approximately 19 clients. In so doing, Luscombe put Integrity's clients in jeopardy because the nurse coming in after did not have the data needed to take care of a patient and Luscombe put Integrity in jeopardy of Medicaid fraud. (BON Tr. 56-60, 62-63; Tr. 156-57 and 168) The Integrity records produced by the Board showed that Luscombe clocked into the client's Telephony system for visits that were not actual patient visits. Integrity paid Luscombe, billed Medicaid, and then when the documentation was received,

reversed the billing to Medicaid. (AHC L.F. 55-57, 71, and 691-712; Tr. 156-57 and 168).

The Board produced a hand-writing expert who compared "known" signatures of Integrity's patients with "questioned signatures" that the Board alleged that Luscombe signed. Lock also compared the questioned signatures with Luscombe's handwriting. The AHC found Lock's testimony to be credible and convincing. (AHC L.F. 64-65). Luscombe testified that she did not falsify any documents for Integrity and that she did not forge patients' signatures. The AHC did not find Luscombe to be a credible witness. (AHC L.F. 66). The AHC accepted Lock's testimony and opinion for patients J.B., T.W., L.F., and K.S. and testified that it was "highly probable" that the questioned signatures were non-genuine. (AHC L.F. 65 and 67).

In those patients who testified and which the AHC did not find that Luscombe signed their names, the AHC noted that the patients' testimony did not undermine the credibility of Lock's testimony, generally, only that the Board failed to meet its burden of proof. In so doing, the AHC noted that in light of the patients' diagnoses, it is possible that they could have been mistaken in their testimony that the signatures were theirs and it was also possible that they were still able to recognize their own signatures. (AHC L.F. 68). This careful analysis by the AHC and its findings that Lock was credible and convincing and Luscombe was not credible, does make for competent and substantial evidence

that there is cause to discipline Luscombe's license for her actions while working at Integrity.

Luscombe argued several times in her brief that she turned in the proper paperwork, it just wasn't on the correct form. (Appellant's Br. 35; Appellant's. Reply Brief 11). This is an attempt to mislead the court. While there were a few records that Luscombe turned in that were not on the correct form, those records "were given back to her at the time that she had turned them in with the correct form to fill out." Integrity did keep a copy of the incorrect form, but the correct forms were not returned for over a year—until August 2008. (Tr. 173-74; AHC L.F. 738-41, 743, 745-52, 818-23 869-73 879-83, 896-900). These records are only 34 of the over 245 records that Luscombe failed to turn in timely or return timely to Integrity. (AHC L.F. 565-666, 727-900, 982-90, and 1015-39). Most importantly, the missing paperwork concerned the care of patients-nurse visit reports and whether visits were made.

D. The AHC's finding of cause to discipline Luscombe's license for her actions while working for Integrity Home Care is not arbitrary, capricious, or unreasonable.

As previously stated, "an agency decision must be made using some kind of objective data rather than mere surmise, guesswork, or 'gut feeling.'" *Bd. of Educ.,* 271 S.W.3d at 11. The Board proved with competent and substantial evidence that Luscombe (a) failed to turn in client records to her employer until

months after the date of service; (b) failed to turn in accurate client records; (c) logged in nurse visits that were missed visits and/or documented as missed visits months later; (d) forged client signatures on four client records; and (e) defrauded her employer, Integrity. The AHC decision was based on established facts and sound reason. It was based on objective data, was not guesswork, and was not arbitrary, capricious, or unreasonable.

III. The Board of Nursing did not err in determining that Luscombe's nursing license should be revoked (Responding to Appellant's Point III).

A. The Board's decision to revoke Luscombe's license is to protect the public and is not punitive.

The legislature vested the Board with the authority to evaluate the severity of the conduct and to determine the appropriate level of discipline to impose. *Johnson v. Mo. Bd. of Nursing Adm'rs,* 130 S.W.3d 619, 643 (Mo. App. W.D. 2004) ("the law leaves the severity of that discipline to the sound discretion of the Board, which is better equipped than the courts to determine the gravity of the infraction and the appropriate sanction. *KV Pharm. Co. v. Mo. State Bd. of Pharmacy,* 43 S.W.3d 306, 310 (Mo. banc 2001)."); *see also Mo. Real Estate Comm'n v. McCormick,* 778 S.W.2d 303, 308 (Mo. App. S.D. 1989), which held: "A determination of the appropriate discipline to be imposed was within the discretion of the MREC." This Court is not authorized to substitute its

discretion for the discretion vested in the licensing board. Its review is limited to deciding whether the licensing board abused its discretion under § 536.140.2(7), RSMo. *Id.* The court in *Tadrus v. Mo. Bd. of Pharmacy,* 849 S.W.2d 222, 228 (Mo. App. W.D. 1993), explained the rationale behind the courts deferring to the administrative agency when it comes to the issue of appropriate discipline:

> The idea of the administrative agency is that its members have a specialized knowledge of the profession they regulate. For that reason, the board is better equipped than the courts to determine the gravity of the infraction of which [the licensee] has been found guilty, and to determine appropriate sanctions.

Luscombe cites *Barry Serv. Agency Co. v. Manning*, 891 S.W.2d 882, 893 (Mo. App. W.D. 1995) for two propositions: (1) that an agency must not make a decision on "mere surmise, guesswork or 'gut feeling'" but on objective data; and (2) an agency acts arbitrarily and capriciously when it fails to consider an important factor before it. (Appellant's Br. 41-42). *Barry Serv.* is distinguishable from this case because the agency decision in *Barry Serv.* was made by the Director of the Division of Finance, it was not a decision made after a contested case. *Barry Serv.*, 891 S.W.2d at 893. As such, the review of non-contested

decisions under § 536.150, RSMo 2000, is de novo, unlike the review we have here.

Luscombe also relies on *Boyd v. State Bd. of Registration for the Healing Arts,* 916 S.W.2d 311 (Mo. App. E.D. 1995) for the proposition that the discipline was too harsh based on the evidence in the administrative record. (Appellant's Br. 41). *Boyd* is distinguishable from the instant case because *Boyd* involved a licensee from another state who was seeking licensure in Missouri and practiced in Missouri for two months without a valid Missouri license. The facts of *Boyd* are hardly similar to the instant case. The Board has the responsibility of protecting the public by ensuring that only those competent to practice hold licenses. The sanction the Board imposed is within the range of available disciplines: censure, probation, suspension, or revocation. Section 335.066.3, RSMo.

Luscombe argues that the discipline is too severe because she has had no prior disciplinary actions and no patient was harmed. (Appellant's Br. 44). A lack of previous disciplinary actions is not an excuse, especially when the AHC found several reasons why her license is now subject to discipline. And, just because the parents of the infant in the hospital's NICU were at the infant's bedside and summoned Luscombe to assist, and because Integrity was not investigated for Medicaid fraud, does not mitigate the potential of harm that could have come in each circumstance. The Board was well aware of this.

The Court of Appeals recently held:

> The court on appeal rarely interferes with sanctions imposed by an administrative [board] which are within the statutory authority of the [board]. A part of the expertise of the members of the [Board] consists of the ability, drawn from their knowledge of the industry practices and standards, to assess the gravity of the licensee's infractions, and to fit the sanction to the offense. (citation omitted).

Kerwin, 375 S.W.3d at 231-32 (noting that the "Board's action was taken after a hearing at which Kerwin appeared and testified with little credibility"). *Id.* at 232. A review of the transcript of the disciplinary hearing in this case brings one to the same conclusion.

Luscombe also argues that the sanction of revocation is punitive, unreasonable, arbitrary and capricious. But, in so doing she appears to forget the purpose of this proceeding is "not the infliction of punishment, but rather the protection of the public." *Duncan,* 744 S.W.2d at 538. "'[T]he focus of licensing laws, and suspension or revocation provisions included therein, is on protection of the public served by such licensed professionals. Cases uniformly reflect this focus with respect to the disciplining of various occupational licenses.'" *Johnson,* 130 S.W.3d at 645.

In *Cooper,* 774 S.W.2d at 503-04, a pharmacist argued that the decision to suspend his license for a year and to place it on probation for five years was unsupported by substantive and competent evidence. The court found that the pharmacist had admitted to the conduct that subjected his license to discipline and thus the penalty imposed by the Board was supported by competent and substantial evidence. The court noted that although there were violations of three statutory provisions, "[u]pon a finding of any **one** statutory violation, the Board may place a pharmacist on probation or suspend or revoke his license. Section 338.055.3, RSMo 1986." (emphasis supplied) *Id.* Section 335.066.3, RSMo, related to nurses, has a similar provision. In this case there were several statutory violations which support cause to discipline Luscombe's license. Therefore, under *Cooper, supra,* there is competent and substantial evidence to support the revocation of Luscombe's license.

Moreover, there was a long contested case hearing in which witnesses testified and exhibits were introduced. The Board members themselves asked numerous questions. A reading of the transcript of the disciplinary hearing evidences that the members of the Board possess a great deal of expertise and take their role very seriously. Several of the questions asked of Luscombe were very pointed. As shown in disciplinary transcript, the Board was very concerned about Luscombe's failure to turn in documentation for at least two reasons: (1) placing the patient in jeopardy; and (2) placing the company at risk for

Medicaid fraud. It is evident that the Board members listened intently to the witnesses' testimony and asked numerous questions of Luscombe. They delved into the facts found by the AHC and tried to figure out why Luscombe, a professional registered nurse, performed her job duties in the manner she did while employed with the hospital and Integrity. (Resp. Sub. App. A47-A59, BON Tr. 56-64 and 71-74).

After the hearing was over, the Board exercised its sound discretion, based on their years of nursing experience, education, skills, and training and imposed the discipline it thought was appropriate to keep the residents of Missouri safe. In the words of Luscombe's former supervisor, Barb Brucks, Luscombe lacks critical thinking and she has failed to recognize the critical nature of her decisions. The Board recognized this in making its decision to revoke her license.

B. The Board did not abuse its discretion in revoking Luscombe's license.

The only evidence that Luscombe offered at the disciplinary hearing, other than her own testimony, was the testimony and letters of witnesses *who had no personal knowledge* of what occurred at the hospital in 2005 and what happened when she worked for Integrity from 2005 to 2007, which is the conduct that brought Luscombe before the Board. While these witnesses may believe that she is good person and has performed well in certain circumstances, none of the

persons who testified on Luscombe's behalf provided rationale for the facts found by the AHC. Even one of her own witnesses, Monte Hanson, testified that he had to terminate her when she was working for him. Although it was not his choice, Mr. Hanson's supervisors felt that Luscombe should no longer work for the nursing home. (BON Tr. 16-20).

Given the length of the disciplinary hearing as well as the attention the Board paid to Luscombe and her witnesses, it is evident they considered the testimony and evidence presented. The fact that the Board decided that the facts and circumstances found by the AHC, as well as the testimony presented by Luscombe herself, weighed heavier towards revoking her license, does not mean that they did not consider the evidence presented by Luscombe's witnesses.

The Board was not required to make the finding suggested by Luscombe in reliance on *Schnell*, 323 S.W.3d at 415, that the Board "cannot disregard unimpeached or undisputed evidence unless the agency make a specific finding that such testimony is not credible or not worthy of belief." (Appellant's Br. 44). The Board could have believed Luscombe's witnesses concerning how she performed in other circumstances and still revoked her license based on the findings of the AHC. It was not an abuse of discretion or unreasonable under the circumstances. Like the Court in *Kerwin*, *supra,* this Court should find no

abuse of discretion requiring appellate interference with the Board's decision in this case.

Luscombe relies on *Gard v. State Bd. of Registration for the Healing Arts*, 747 S.W.2d 726, 729 (Mo. App. W.D. 1988), for the proposition: "[w]here a licensing board ignores facts and circumstances in the record without consideration, such discipline should be overturned." (Appellant's Br. 42). The court in *Gard* made it abundantly clear that its holding was limited to the facts of that case—which involved rehabilitation after a criminal conviction. The court actually stated: "What the Board here has done is to ignore the facts and circumstances of appellant's rehabilitation." *Id.* The court further emphasized that when it found that the Board had abused its discretion, it was doing it "*under the particular facts here.*" *Id.* at 730. Unlike *Gard*, this case does not deal with rehabilitation after a criminal conviction, but on actions that occurred while working in the profession. The Board also had two determinations by the AHC that Luscombe herself was not credible. (AHC L.F. 66 and 70). This court must defer to the AHC's determination on the credibility of witnesses. *Kerwin, supra.*

At the disciplinary hearing Luscombe, in responding to the Board's questions, still did not give a credible explanation as to why it took her so long to turn the patient records into Integrity. She gave yet another explanation involving a car. (Resp. Sub. App. A57-58; BON Tr. 72-73). Regardless of how

glowing an account Luscombe's witnesses gave of the quality of her work in other circumstances, this testimony cannot override the fact that Luscombe herself was not credible. It also was apparent that she still did not understand the magnitude of what could have happened by her failure to timely turn in records or to suspend a cardiac monitor. The Board members, with their expertise, recognized that Luscombe's actions could have put patients as well as her employer in jeopardy. (Resp. Sub. App. A54; BON Tr. 63). The Board, entrusted with the responsibility of protecting the public, did not abuse its discretion in revoking Luscombe's license.

C. The Board's decision to revoke Luscombe's license was reasonable.

In cases such as these, the Board's decision may be overturned only upon a showing that the agency's decision is unsupported. An agency's decision is unsupported by competent and substantial evidence only in the rare case when the decision is contrary to the overwhelming weight of the evidence. *Hampton v. Big Boy Steel Erection*, 121 S.W.3d 220, 223 (Mo. 2003). The Board had competent and substantial evidence on which to base its decision. It had a long detailed decision in front of it with serious reasons as to why her license was subject to discipline, among those: (1) she suspended an infant cardiac monitor in violation of a hospital's protocol of which she was aware, and this was gross negligence and a violation of professional trust; (2) she obtained a fee by fraud,

deception, and misrepresentation and it was incompetency and misconduct when she (a) failed to turn in client records to her employer until months after the date of service; (b) failed to turn in accurate client records; (c) logged in nurse visits that were missed visits and/or documented as missed visits months later; and (d) forged client signatures on four client records; and (3) Luscombe defrauded her employer, Integrity, and this constitutes a violation of a professional trust. The Board's decision was based on competent and substantial evidence and it is not unreasonable.

Conclusion

For the reasons stated above, the Court should affirm the administrative decisions of the Administrative Hearing Commission and the Missouri State Board of Nursing.

Respectfully submitted,

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Certification of Service and of Compliance with Rule 84.06(b) and (c)

The undersigned hereby certifies that on this 5th day of August 2013 one true and correct copy of the foregoing brief was served on Petitioner's attorney via efiling with the Missouri Supreme Court to:

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The undersigned further certifies that the foregoing brief complies with the limitations contained in Rule No. 84.06(b) and that the brief contains 11,728 words.

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